PATIENTS' BILL OF RIGHTS

PART I: PATIENT ACCESS TO MEDICAL ADVICE AND CARE

Continuity of Care in HMOs
Requires managed care plans to allow enrollees with an "ongoing special condition" (e.g., 2d trimester of pregnancy or later, life-threatening illness, scheduled surgery, organ transplant, etc.) to continue receiving services from a doctor or other provider for a transition period when (1) the provider leaves the plan network, or (2) the enrollee has involuntarily changed to a plan that does not include the provider. The length of the transition period depends on the enrollee's condition (e.g., in cases of pregnancy, the period continues through completion of postpartum care).

Extended or Standing Referral to Specialist
Clarifies existing legislation to allow minors needing an extended referral to a specialist must be allowed access to a specialist who also has expertise in treating children. Also clarifies that, for all age groups, plans must allow referral to a nonparticipating specialist if an in-plan specialist is unavailable. Enrollee pays same co-insurance or co-payment as he or she would for in-plan services.

Specialist as Primary Care Physician
Insurers must allow an enrollee to select a specialist as his or her primary care physician if the enrollee suffers from a condition requiring specialty care over a prolonged period of time.

Direct Access to Pediatricians
Requires insurers to allow enrollees to select a pediatrician as their minor child's primary care physician.

Access to Nonformulary and Restricted Access Prescription Drugs
Requires insurers to cover prescription drugs that are otherwise restricted by the plan if the drugs are medically necessary to treat an enrollee's covered condition.

Ombudsman Program
Establishes the office of the Managed Care Ombudsman to assist enrollees with their managed care plans. Ombudsman will provide information and advice and help patients obtain the benefits they are entitled to under the plan. The Governor will appoint the Ombudsman and funding will be through fees collected from insurers.

PART II. HEALTH PLAN DISCLOSURES

Managed Care Reporting and Disclosure Requirements
Requires insurers to disclose information concerning the availability of drugs that are otherwise restricted by the plan.

Provider Directory Information
Requires insurers to have current information about their provider networks available to consumers by telephone, Internet, etc., so that consumers can determine whether a provider is currently in the plan's network.

Disclosure of Payment Obligations
The plan must explain any financial obligation the patient will incur that exceeds the patient's fixed co-payment.

PART III. MANDATED BENEFITS*
(*Health care services/treatment insurers are required to cover by law.)